HEPATITIS A CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health
State Form 49690 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ●⊗
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of: ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever ___.___ *(degrees)*
- ○ Diarrhea
- ○ Nausea/Vomiting
- ○ Abdominal Pain
- ○ Pale Stool
- ○ Dark Urine
- ○ Fatigue
- ○ Loss of Appetite
- ○ Jaundice, if yes, onset date: / /
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Hepatitis A IgM result:
- ○ Positive
- ○ Negative
- ○ Unknown/Not Tested

SGOT (AST)

SGPT (ALT)

Bilirubin

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code**

Physician/Hospital Phone

Was the patient hospitalized?

○ Yes ○ No **If Yes, admission date:** / /

Discharge date: / /

Hospital:

Was patient previously vaccinated for hepatitis A?

○ Yes ○ No **If Yes, manufacturer:**

Dosage date: / /

Did the patient die?

○ Yes ○ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 7 weeks prior to illness onset.

1. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

2. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

3. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

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Section 3. Epidemiologic Information (continued)

4. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

List all group gatherings where food was served that the patient attended during the 7 weeks prior to illness onset.

1. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

2. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

List all stores where the patient bought groceries that were consumed during the 7 weeks prior to illness onset.

Store Name:	Store Address:	Date:
		/ /
		/ /
		/ /

Section 4. Risk Factors

During the 7 weeks prior to illness onset, was the patient:

A child in a child-care setting?

○ Yes ○ No ○ Unknown

If Yes, specify child-care facility

A household contact of a child or employee in a child-care setting?

○ Yes ○ No ○ Unknown

If Yes, specify child-care facility

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Section 4. Risk Factors (continued)

During the 7 weeks prior to illness onset, was the patient:

A contact of a confirmed or suspected hepatitis A case?

○ Yes ○ No ○ Unknown **If Yes, name:**

Phone number: ___ - ___ - ____

If Yes, specify type of contact:

○ Sexual ○ Household ○ Other, specify:

Involved in any type of food handling?

○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __
Date

Did the patient eat any raw shellfish?

○ Yes ○ No ○ Unknown

If Yes, which shellfish

Where

__ / __ / __
Date

Was the patient suspected as being part of a common-source foodborne or waterborne outbreak?

○ Yes ○ No ○ Unknown

If Yes, describe

Travel outside of Indiana?

○ Yes ○ No ○ Unknown

If Yes, where

__ / __ / __ **Date of departure** __ / __ / __ **Date of return**

Use street drugs?

○ Yes ○ No ○ Unknown

If Yes, describe

Number of sexual partners during last 7 weeks:

Males: __ **Females:** __ ○ **None** ○ **Unknown**

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Section 4. Risk Factors (continued)

Does the patient know anyone else who has recently had an illness characterized by diarrhea, nausea/vomiting, or jaundice?

○ Yes ○ No ○ Unknown

If Yes, name:

Phone number: ___ - ___ - ____

Onset date: __ / __ / __

Relationship:

Was this person exposed to any of the same commercial food establishments, group gatherings, or travel history as the patient?

○ Yes ○ No ○ Unknown

If Yes, describe

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

___ - ___ - ____ **Phone Number**

__ / __ / __ **Date**